SCHMERZTHERAPIE-UND OSTEOPATHIE-ZENTRUM DÖBLING®

„I see a complete universe in every single human being“ (Dr. Still, Founder of ostepathy)

Pain Questionnaire

Family name: ..... **First name:** .....

Address: .....

ZIP: ..... **City:** .....

Phone.: ..... **Mobile:** .....

Insurance no.: ..... **Insurance co.:** ..... **Date of Birth.:** ..... **Sex:** F ☐ M ☐

Employment: ..... **Employer:** .....

E-mail: ..... **Marital Status:** .....

1. **Where do you feel pain?**

   .....

2. **I don’t suffer from pain, i have troubles with:**

Troubles	Since when	remarks

3. **What do you think your pain/ troubles have its seeds in?**

   .....

4. **Can you see a connection with anything?**

   .....

5. **Is your pain radiating to other areas?**

   YES ☐ NO ☐

   If yes, where does it start and to where does it lead?

   .....

6. **How would you describe your pain? (please circle the following)**

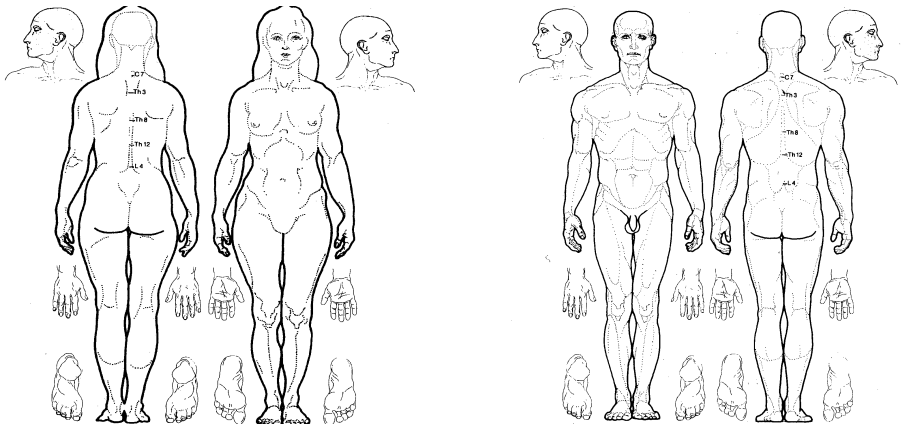
Pulling/ pinching/ stabbing/ tingling/ cramping/ dull/ burning/ knifelike/ throbbing/ biting/ continuous

Any other description? .....

7. **On the scale below, please markt he pain intensity:** (0=no pain – 10=worst pain)

0 1 2 3 4 5 6 7 8 9 10

8. **In the sketch below, please mark origins and ways of the pain:**



9. **How often do you feel pain?**

.....

10. **Please characterize the pain**

Sudden pain attacks/ continuous pain

11. **How long do the episodes last?**

.....

12. **Since when do you feel this pain?**

.....

13. **Has the pain increased recently?**

YES ☐ *NO* ☐

14. **If yes, since when?**

.....

15. **During what time of day do you feel the worst pain?**

Daytime/nighttime

16. Is the pain triggered or increased by activity of by any other circumstances?

YES ☐ *NO* ☐

If yes, by which?.....

17. Does the pain increase when keeping certain positions/postures (sitting or standing, for a long time)?

YES ☐ *NO* ☐

18. Do you exercise any sport regularly?

YES ☐ *NO* ☐

If yes, which one? .....

19. What kind of hobbies do you have (regularly)?

.....

20. Does anybody else in your family suffer from pain episodes?

.....

21. Is the pain intensity influenced by weather?

YES ☐ *NO* ☐

22. Did you have any important surgerys? When?

Surgery	**When**	**Remarks**

23. Did you have any accidents? (Please name all accidents you had)?

Accident	**When**	**Remarks**

24. Do or did you have any diseases at following organs?

Organ	Yes	No	Remarks
Heart			
Brain			
Lungs			
Thyroid gland			
Joints			
Gastrointestinal tract			
Liver			
Kidney			
Other			

25. Did or do you have any of the following diseases?

	Yes	No	Remarks
Diseases			
Rheumatism			
Diabetes			
High blood pressure			
Mind			
Infectios diseases			
Other			

26. Do you believe that your pain was triggered by a specific event? (eg. Disease, surgery, accident, stressful life, event, pregnancy, etc.)

.....

27. Do you smoke?

- ☐ Never
- ☐ I did smoke, i stopped .....
- ☐ Yes. Since when? How much? .....
- ☐ I would like to quit

28. How well do you sleep?

Very well/ problems falling asleep/ problems staying asleep/ the pain keeps waking me up

29. Which medication do you take/ for how long/ which dosage?

Medication	**How often?**	**For how long?**

30. Which medication on your list have you tolerated well?

.....

31. Which medication on your list have you <u>not</u> tolerated well? Which adverse reactions do you experience? (please explain shortly)?

.....

32. Do you have any food and/or drug allergies?

.....

33. How do you treat your pain?

Not at all/ with medication/ with warm temperatures/ with cold temperatures/ with physical activity/ by pressing the pain source/ with relaxation/ by keeping a certain position/ any different ways? .....

34. Are you currently receiving pension money or will you do so in the near future?

YES ☐ *NO* ☐

If yes, for how long?.....

35. For how long has your pain kept you off your job and / or from performing every day life activities? .....

36. Which doctors, hospitals, ambulaces or institutes have you consulted for pain treatment until now? (eg. General practitioner, orthopedist, chiropractitioner,…)

.....

37. Which forms and methods of treatment were tried? Did they increase, decrease or eliminate the pain?

Treatment/Method/Operation	Increased	Decreased	Eliminate

38. For women: (optional) Questions to your health:

Questions	Yes	No	Remarks
Do you take a birth control pill?			
Is you menstrual period regulary?			
Do you suffer from pain in your abdomen during your menstrual period?			
Do you suffer pain in your back during your menstrual period?			
Are you bad-humoured during this time?			
Are you pregnant?			
Did you have any pregnancies? If yes, how many?			
How was your pregnancy for you?			
How often did you give birth?			
Did you have any C-sections? If yes, how many?			
How did you experience the births of your children?			
Did you have any complications			

during the childbirth?			
Other remarks:			

39. Is there anything you`d like to ask/ Additional remarks: .....

.....

.....

.....

.....

40. How did you find us?

Friends / Family/ Homepage/ Internet

Other: .....

41.How do you imagine your treatment in our center? How can we help you?

.....

After filling in this form, please take it with you at you firt appointment, fax, or mail it to us.

Fax: 01/36 70 700-7, E-Mail: office@stz.at

If you can't make it, please inform us 24hours before your appointment.

Patient signature:

Humans are so much more than a sum of their parts. They are a unity out of body, soul and spirit!"

(OA Dr. Selim MSc, neurologist & osteopath, 2016)

„You start a life free of pain here and now."
(OA Dr. Selim MSc, neurologist & osteopath, 2016)